		FOR BHF USE					

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042648

Facility Name: Manorcare of Northbrook

Address: 3300 Milwaukee Avenue (Number) Northbrook (City) 60062 (Zip Code)

County: Cook

Telephone Number: (847) 795-9700 **Fax #** (847) 795-9600

HFS ID Number: 520886946022

Date of Initial License for Current Owners: 03/22/99

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[X]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany, CPA **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 06/01/04 to 05/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Barry Lazarus
(Title) Vice President of Reimbursement

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Manorcare of Northbrook # 0042648 Report Period Beginning: 06/01/04 Ending: 05/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	158	Skilled (SNF)	158	57,670	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	158	TOTALS	158	57,670	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,095	15,038	25,069	55,202	8
9	SNF/PED					9
10	ICF	273			273	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,368	15,038	25,069	55,475	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.19%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 3/22/99

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 158 and days of care provided 6,516

Medicare Intermediary Care First of Maryland

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [X]

Tax Year: 12/31/05 Fiscal Year: 05/31/05

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Manorcare of Northbrook # 0042648 **Report Period Beginning:** 06/01/04 **Ending:** 05/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	292,492	20,452	121	313,065	2,631	315,696		315,696			1
2	Food Purchase		192,368		192,368		192,368	(2,557)	189,811			2
3	Housekeeping	183,520	29,154	344	213,018		213,018		213,018			3
4	Laundry	71,613	10,591		82,204		82,204	(4,484)	77,720			4
5	Heat and Other Utilities			125,334	125,334	6,069	131,403	(10,294)	121,109			5
6	Maintenance	46,655	17,549	41,564	105,768		105,768		105,768			6
7	Other (specify):* **Medical Waste**			2,328	2,328		2,328		2,328			7
8	**TOTAL General Services**	594,280	270,114	169,691	1,034,085	8,700	1,042,785	(17,335)	1,025,450			8
	B. Health Care and Programs											
9	Medical Director			13,750	13,750		13,750		13,750			9
10	Nursing and Medical Records	2,493,746	187,162	20,510	2,701,418	44,866	2,746,284	(2,446)	2,743,838			10
10a	Therapy	280,946	12,375	231,375	524,696		524,696		524,696			10a
11	Activities	96,001	9,973	1,253	107,227		107,227		107,227			11
12	Social Services	101,195	65	781	102,041		102,041		102,041			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,971,888	209,575	267,669	3,449,132	44,866	3,493,998	(2,446)	3,491,552			16
	C. General Administration											
17	Administrative	47,208		352,291	399,499	(112,753)	286,746		286,746			17
18	Directors Fees											18
19	Professional Services			11,676	11,676	(662)	11,014	(11,014)				19
20	Dues, Fees, Subscriptions & Promotions			82,456	82,456		82,456	(25,699)	56,757			20
21	Clerical & General Office Expenses	212,050	42,497	97,397	351,944	662	352,606	(67,297)	285,309			21
22	Employee Benefits & Payroll Taxes			702,383	702,383	41,247	743,630		743,630			22
23	Inservice Training & Education			5,136	5,136		5,136		5,136			23
24	Travel and Seminar			4,946	4,946		4,946		4,946			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			171,278	171,278		171,278		171,278			26
27	Other (specify):*											27
28	**TOTAL General Administration**	259,258	42,497	1,427,563	1,729,318	(71,506)	1,657,812	(104,010)	1,553,802			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,825,426	522,186	1,864,923	6,212,535	(17,940)	6,194,595	(123,791)	6,070,804			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Manorcare of Northbrook #0042648 **Report Period Beginning:** 06/01/04 **Ending:** 05/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			467,120	467,120	17,940	485,060		485,060			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							(1,196)	(1,196)			32
33	Real Estate Taxes			173,001	173,001		173,001	105,606	278,607			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			53,091	53,091		53,091		53,091			35
36	Other (specify):*											36
37	**TOTAL Ownership**			693,212	693,212	17,940	711,152	104,410	815,562			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		211,638	42,059	253,697		253,697		253,697			39
40	Barber and Beauty Shops			31,928	31,928		31,928		31,928			40
41	Coffee and Gift Shops	21,462			21,462		21,462		21,462			41
42	Provider Participation Fee			86,505	86,505		86,505		86,505			42
43	Other (specify):*		42,085		42,085		42,085		42,085			43
44	**TOTAL Special Cost Centers**	21,462	253,723	160,492	435,677		435,677		435,677			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,846,888	775,909	2,718,627	7,341,424		7,341,424	(19,381)	7,322,043			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Manorcare of Northbrook # 0042648 Report Period Beginning: 06/01/04 Ending: 05/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,557)	2		4
5	Telephone, TV & Radio in Resident Rooms	(10,294)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(4,484)	4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,196)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,446)	10		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(11,014)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(64,134)	21		24
25	Fund Raising, Advertising and Promotional	(25,699)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	105,606	33		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(3,163)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (19,381)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (19,381)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Manorcare of Northbrook

ID# **0042648**

Report Period Beginning: **06/01/04**

Ending: **05/31/05**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Phone	$ (2,062)	21	1
2	Customer Reimbursement	(1,054)	21	2
3	General Store	(47)	21	3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(3,163)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Manorcare of Northbrook # 0042648 **Report Period Beginning:** 06/01/04 **Ending:** 05/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,557)	0	0	0	0	0	0	0	0	0	0	(2,557)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(4,484)	0	0	0	0	0	0	0	0	0	0	(4,484)	4
5	Heat and Other Utilities	(10,294)	0	0	0	0	0	0	0	0	0	0	(10,294)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(17,335)	0	0	0	0	0	0	0	0	0	0	(17,335)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(2,446)	0	0	0	0	0	0	0	0	0	0	(2,446)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,446)	0	0	0	0	0	0	0	0	0	0	(2,446)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(11,014)	0	0	0	0	0	0	0	0	0	0	(11,014)	19
20	Fees, Subscriptions & Promotions	(25,699)	0	0	0	0	0	0	0	0	0	0	(25,699)	20
21	Clerical & General Office Expenses	(67,297)	0	0	0	0	0	0	0	0	0	0	(67,297)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(104,010)	0	0	0	0	0	0	0	0	0	0	(104,010)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(123,791)	0	0	0	0	0	0	0	0	0	0	(123,791)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Manorcare of Northbrook** **#** **0042648** **Report Period Beginning:** **06/01/04** **Ending:** **05/31/05**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,196)	0	0	0	0	0	0	0	0	0	0	(1,196)	32
33	Real Estate Taxes	105,606	0	0	0	0	0	0	0	0	0	0	105,606	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	104,410	0	0	0	0	0	0	0	0	0	0	104,410	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(19,381)	0	0	0	0	0	0	0	0	0	0	(19,381)	45

Facility Name & ID Number Manorcare of Northbrook # 0042648 Report Period Beginning: 06/01/04 Ending: 05/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)	Toledo, OH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		See Page 8		$ 352,291	HCR Manor Care, Inc	100.00%	$ 352,291	$	1
2	V									2
3	V									3
4	V									4
5	V									5
6	V		10a	Therapy Management	26,406	Heartland Management Services	100.00%	26,406		6
7	V									7
8	V									8
9	V									9
10	V									10
11	V									11
12	V									12
13	V									13
14	Total				$ 378,697			$ 378,697	$ *	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Manorcare of Northbrook # 0042648 Report Period Beginning: 06/01/04 Ending: 05/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION**

Facility Name & ID Number Manorcare of Northbrook # 0042648 Report Period Beginning: 06/01/04 Ending: 05/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR Manor Care, Inc
Street Address: 333 North Summit St
City / State / Zip Code: Toledo, OH 43604
Phone Number: (419) 252-5500
Fax Number: (419) 254-5494

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	$	$		$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	1,043,233	571,891	7,133,563	2,631	2
3	5	Utilities - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	223,707		7,133,563	675	3
4	5	Utilities - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	2,139,042		7,133,563	5,394	4
5	10	Nursing - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	12,987,607	8,226,246	7,133,563	39,187	5
6	10	Nursing - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	2,252,260	1,199,059	7,133,563	5,679	6
7	17	General & Admin - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	16,611,639	15,056,893	7,133,563	50,121	7
8	17	General & Admin - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	75,121,310	43,509,256	7,133,563	189,418	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac	3,924,545		7,133,563	11,841	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	11,662,215		7,133,563	29,406	10
11	30	Depreciation - Direct	Accumulated Cost	2,364,266,309	369 Nurs Fac			7,133,563	0	11
12	30	Depreciation - Pooled	Accumulated Cost	2,829,104,777	369 Nurs Fac	7,114,804		7,133,563	17,940	12
13										13
14	32	Interest				10,002,527				14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 143,082,889	$ 68,563,345		$ 352,292	25

Facility Name & ID Number Manorcare of Northbrook # 0042648 Report Period Beginning: 06/01/04 Ending: 05/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5								Interest Income			(1,196)	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$ (1,196)	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ (1,196)	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Manorcare of Northbrook **#** 0042648 **Report Period Beginning:** 06/01/04 **Ending:** 05/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	166,171	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	271,777	2
3. Under or (over) accrual (line 2 minus line 1).	$	105,606	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	171,251	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	1,750	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	278,607	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	318,349	8
	2001	245,778	9
	2002	240,453	10
	2003	241,893	11
	2004	171,251	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Manorcare of Northbrook COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0042648

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	04-30-200-013-0000	See Attached	$ 2,209.20	$ 2,209.20
2.	04-30-200-020-0000	See Attached	$ 36,332.84	$ 36,332.84
3.	04-30-200-024-0000	See Attached	$ 11,069.02	$ 11,069.02
4.	04-30-200-025-0000	See Attached	$ 81,200.39	$ 81,200.39
5.	04-30-200-013-0000	See Attached	$ 2,549.48	$ 2,549.48
6.	04-30-200-020-0000	See Attached	$ 11,096.42	$ 11,096.42
7.	04-30-200-024-0000	See Attached	$ 2,648.02	$ 2,648.02
8.	04-30-200-025-0000	See Attached	$ 24,145.60	$ 24,145.60
9.			$	$
10.			$	$
		TOTALS	$ 171,250.97	$ 171,250.97

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Manorcare of Northbrook # 0042648 Report Period Beginning: 06/01/04 Ending: 05/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 65,393 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1999	$ 1,885,717	1
2			2003	32,884	2
3	TOTALS			$ 1,918,601	3

Facility Name & ID Number Manorcare of Northbrook # 0042648 Report Period Beginning: 06/01/04 Ending: 05/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	148			1999	$ 8,207,461	$ 229,500		$ 229,500	$	$ 1,054,270	4
5	CR 5/31/01 AUDIT ADJ			1999	494,486						5
6	10			2003	478,057						6
7											7
8											8
	Improvement Type**										
9	BUILDING IMPROVEMENTS (Current Year Depreciation)					97,322		97,322		177,558	9
10				1999	531						10
11	CR 5/31/01 AUDIT ADJ			1999	(531)						11
12				1999	1,470						12
13	CR 5/31/01 AUDIT ADJ			1999	(1,470)						13
14				1999	73						14
15	CR 5/31/01 AUDIT ADJ			1999	(73)						15
16				1999	449						16
17	CR 5/31/01 AUDIT ADJ			1999	(449)						17
18	SECURE CARE SYSTEM			2000	14,841						18
19	MAGNETIC DOOR HOLDER			2000	1,134						19
20	ACCESS DOORS - FIRE DAMPERS			2000	2,473						20
21	ENGINEER COST V#3413 RESIDENT'S ROOMS			2000	14,790						21
22	WALLCOVERING-2ND FL RESIDENTS R			2000	1,398						22
23	ADDT'L CONSTRUCTION COST-RESIDENTS ROOMS			2000	205						23
24	CIRCUITRY SECURE CARE SYSTEM			2000	1,374						24
25	SITEWORK			2000	1,036,860						25
26	CR 5/31/01 AUDIT ADJ			2000	(1,036,860)						26
27	FENCE			2000	965						27
28	BLOCKING AND PULLY SYSTEM			2001	977						28
29	ELECTRICAL ON GENERATOR			2001	1,298						29
30	FREIGHT ON CARPET			2001	103						30
31	CARPET			2001	484						31
32	CARPET			2001	626						32
33	GEN OVERHEAD,ARCHITECT,ENGINEER COSTS			2003	395,966						33
34	MILLWORK			2003	2,646						34
35	CARPET			2003	3,248						35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Manorcare of Northbrook # 0042648 Report Period Beginning: 06/01/04 Ending: 05/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37		2003	$ 840	$		$	$	$	37
38		2003	188						38
39	CARPET, BADE AND TILE	2003	2,275						39
40	FREIGHT ON CARPET	2003	60						40
41	FREIGHT ON CARPET	2003	69						41
42	CARPET	2003	835						42
43	ARCHITECT COSTS	2003	848						43
44	ENGINEERING & ARCHITECT COST	2003	1,680						44
45	ENGINEERING & ARCHITECT COST	2003	738						45
46	CERMAIC TILE	2003	2,450						46
47	FREIGHT ON CARPET	2003	69						47
48	VINYL WALL COVERING	2003	148						48
49	CARPET	2003	620						49
50	VINYL WALL COVERING	2003	201						50
51	ENGINEERING COSTS	2003	3,647						51
52	SITE PREPARATION COSTS	2003	71,550						52
53	ADDTL CIVIL ENGINEERING COST	2004	1,800						53
54	ADDTL ARCHITECTURAL COST	2004	30						54
55	CERAMIC TILE	2004	1,093						55
56	CARPET	2004	707						56
57	ENGINEERING COSTS	2004	125						57
58	FREIGHT ON VINYL	2004	62						58
59	INSTALLATION OF COUNTERTOPS AND CONCRETE	2004	12,653						59
60	COMPLETION OF BORDER AND WALL COVERINGS	2004	7,980						60
61	VINYL WALL COVERING	2004	989						61
62	VINYL WALL COVERING	2004	77						62
63	VINYL WALL COVERING	2004	407						63
64	VINYL WALL COVERING	2004	672						64
65	VINYL WALL COVERING	2004	801						65
66	DRYWALL INSTALLATION FOR LAUNDRY ROOM	2004	1,382						66
67	VINYL WALL COVERING	2004	660						67
68	WINDOW TREATMENTS	2004	2,097						68
69	COMPLETE ADDITIONAL WALL VINYL PATCH	2004	450						69
70	TOTAL (lines 4 thru 69)		$ 9,740,735	$ 326,822		$ 326,822	$	$ 1,231,828	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Manorcare of Northbrook # 0042648 Report Period Beginning: 06/01/04 Ending: 05/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 1,316,319	$ 140,298	$ 140,298	$		$ 608,896	71
72	Current Year Purchases	34,473						72
73	Fully Depreciated Assets							73
74	Home Office Allocation			17,940	17,940			74
75	TOTALS	$ 1,350,792	$ 140,298	$ 158,238	$ 17,940		$ 608,896	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 13,010,128	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 467,120	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 485,060	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 17,940	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,840,724	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 53,091 Description: O2 Concentrators,Wheelchairs,Gerichairs,Elect Beds, Etc.
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Manorcare of Northbrook # 0042648 Report Period Beginning: 06/01/04 Ending: 05/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER CNA ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	4264 hrs	$ 122,457	3,961	$ 99,025	$ 1,253	8,225	$ 222,735	1
2	Licensed Speech and Language Development Therapist	10a	1158 hrs	33,257	1,172	29,309	358	2,330	62,924	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	4360 hrs	125,232	4,122	103,041	10,764	8,482	239,037	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				211,638		211,638	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): P/S-Lab,X-Ray, Inhal	10,Col 3, 39				42,059			42,059	13
14	TOTAL			$ 280,946	9,255	$ 273,434	$ 224,013	19,037	$ 778,393	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Manorcare of Northbrook **#** 0042648 **Report Period Beginning:** 06/01/04 **Ending:** 05/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 05/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 33,676	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (130,391))	793,570		3
4	Supply Inventory (priced at)	48,892		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	6,606		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 882,744	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	1,918,601		13
14	Buildings, at Historical Cost	9,740,736		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,350,791		16
17	Accumulated Depreciation (book methods)	(1,840,725)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 11,169,403	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,052,147	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 72,287	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	394,262		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	171,251		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	69,074		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 706,874	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 706,874	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 11,345,273	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,052,147	$	48

***(See instructions.)**

Facility Name & ID Number Manorcare of Northbrook # 0042648 Report Period Beginning: 06/01/04 Ending: 05/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 11,402,710	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 11,402,710	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	878,890	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 878,890	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(936,327)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (936,327)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 11,345,273	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,228,219	1
2	Discounts and Allowances for all Levels	(1,470,422)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,757,797	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,183,836	6
7	Oxygen	(114)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,183,722	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,061	12
13	Barber and Beauty Care	46,630	13
14	Non-Patient Meals	2,097	14
15	Telephone, Television and Radio	2,062	15
16	Rental of Facility Space		16
17	Sale of Drugs	207,434	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	12,831	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	4,484	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 277,599	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	(116)	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ (116)	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Misc Income	1,312	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,312	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 8,220,314	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,034,085	31
32	Health Care	3,449,132	32
33	General Administration	1,729,318	33
	B. Capital Expense		
34	Ownership	693,212	34
	C. Ancillary Expense		
35	Special Cost Centers	435,677	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 7,341,424	40
41	**Income before Income Taxes (line 30 minus line 40)****	878,890	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 878,890	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,733	1,883	$ 64,265	$ 34.13	1
2	Assistant Director of Nursing	2,688	2,920	84,542	28.95	2
3	Registered Nurses	30,969	33,648	926,547	27.54	3
4	Licensed Practical Nurses	10,694	11,619	258,566	22.25	4
5	CNAs & Orderlies	85,365	92,749	1,120,240	12.08	5
6	CNA Trainees					6
7	Licensed Therapist	8,954	9,679	278,019	28.72	7
8	Rehab/Therapy Aides	194	210	2,927	13.94	8
9	Activity Director					9
10	Activity Assistants	7,692	8,357	96,001	11.49	10
11	Social Service Workers	5,016	5,458	101,195	18.54	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	22,068	24,122	292,492	12.13	15
16	Dishwashers					16
17	Maintenance Workers	1,961	2,147	46,655	21.73	17
18	Housekeepers	16,260	17,669	183,520	10.39	18
19	Laundry	7,901	8,588	71,613	8.34	19
20	Administrator	1,322	1,322	47,208	35.71	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,697	13,691	233,512	17.06	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,834	3,084	39,586	12.84	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	218,348	237,146	$ 3,846,888 *	$ 16.22	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	13,750	Ln 9, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 13,750		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Manorcare of Northbrook # 0042648 Report Period Beginning: 06/01/04 Ending: 05/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Nick Stamatakos	Administrator	0	$ 23,604
Diane Lube	Administrator	0	7,868
Terri Bowen	Administrator	0	15,736
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 47,208

B. Administrative - Other

Description	Amount
Home Office	$ 352,291
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 352,291

C. Professional Services

Vendor/Payee	Type	Amount
		$
Foote,Meyers,Mielke & Flowers, LL	Legal Fees	11,014
Physicians Credit Bureau	Acct Fees	557
Judi Kolmos	Spec Conslt	105
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 11,676

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 22,450
Unemployment Compensation Insurance	59,830
FICA Taxes	277,535
Employee Health Insurance	305,777
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401K	28,636
Other Employee Benefits	4,972
Tuition Program	2,854
Employee Uniforms	329
Payroll Overhead Allocated	0
Home Office Allocation	41,247
TOTAL (agree to Schedule V, line 22, col.8)	$ 743,630

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 8,570
Advertising: Employee Recruitment	22,192
Health Care Worker Background Check	
(Indicate # of checks performed 88)	1,752
Advertising	42,328
Association Dues	7,614
Less: Non-Allowable Association Dues	(2,457)
Less: Public Relations Expense	( )
Non-allowable advertising	(23,242)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 56,757

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,946
Includes travel expense to the Home	
Office in Toledo, OH for regional	
meeting	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,946

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Manorcare of Northbrook # 0042648 Report Period Beginning: 06/01/04 Ending: 05/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number **Manorcare of Northbrook** **#** **0042648** **Report Period Beginning:** **06/01/04** **Ending:** **05/31/05**

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $ 7,614**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes $ 2,457**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **88,769** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **86,505**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **(2,097)**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.